

**HEALTH HISTORY FORM**

**(PLEASE COMPLETE ALL FIELDS)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Current Date: \_\_\_\_\_

Do you have an Advance Directive Yes / No If no, would you like information Yes / No

**Physician/Provider List (PCP, Referring - any provider you would like to receive a copy of your notes)**

<u>Physician/Provider Name</u>	<u>Phone number</u>	<u>Location</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PERSONAL MEDICAL HISTORY:**

<u>Diagnosis or Condition:</u>	<u>Date or Year of Diagnosis:</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*(continue on back if needed)*

Have you ever had a pneumonia vaccine: yes / no If so, when: \_\_\_\_\_

Please list all **Surgeries/Procedures** you've had and **Date/Year Performed:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**GYNECOLOGICAL HISTORY (for women):**

# of pregnancies _____	Contraceptive Hormone Use: Yes / No # of years _____
# of full term births _____	Post-Menopause Use: Yes / No # of years _____
# of preterm births _____	Other Hormone Use: Yes / No # of years _____
Age at first birth _____	Date or year of last pap smear: _____
Age at first period _____	Results: _____
Date of last period _____	Date or year of last mammogram: _____
Average # of days between periods _____	Results: _____
Menopause Status: Pre / Peri / Post / Unknown	
Age at menopause _____ Reason: Natural / Removal ovaries / Removal uterus / Total hysterectomy / Surgical / Other	

**FAMILY HISTORY:** Please circle yes or no if a blood relative has ever been diagnosed with any of the following:

	<u>Relationship To You</u>		<u>Relationship To You</u>
diabetes	Yes / No _____	thyroid disease	Yes / No _____
heart disease/attack	Yes / No _____	anemia	Yes / No _____
high blood pressure	Yes / No _____	leukemia	Yes / No _____
stroke	Yes / No _____	bleeding tendency	Yes / No _____
osteoporosis	Yes / No _____	chronic lung disease	Yes / No _____
kidney disease	Yes / No _____	melanoma	Yes / No _____

**FAMILY HISTORY FOR COMMON HEREDITARY CANCER SYNDROMES:**

Please circle yes or no if a blood relative has ever been diagnosed with any of the following:

**Breast & Ovarian Cancer**

	Yes / No	<u>Relationship to You</u>	<u>Age at Diagnosis</u>
Breast cancer before age 50	Yes / No	_____	_____
Ovarian cancer	Yes / No	_____	_____
Breast & ovarian cancer in an individual or family	Yes / No	_____	_____
Male breast cancer	Yes / No	_____	_____
Breast cancer in both breasts or multiple primary breast cancers	Yes / No	_____	_____
2 or more breast or ovarian cancers in an individual or family	Yes / No	_____	_____
Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer	Yes / No	_____	_____

**Colon & Uterine Cancer**

10 or more colon polyps found in a lifetime	Yes / No	_____	_____
Uterine cancer before age 50	Yes / No	_____	_____
Colorectal cancer before age 50	Yes / No	_____	_____
Both uterine & colorectal cancer in an individual or family	Yes / No	_____	_____
2 or more uterine or colorectal cancers in an individual or family	Yes / No	_____	_____
Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer in an individual or family	Yes / No	_____	_____

Any other family history of cancer: Yes / No

If yes, list type of cancer & relationship of family member: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please list Health Status as Good, Fair, or Poor**

**Father**

If living: Age \_\_\_\_\_ Health Status \_\_\_\_\_  
 If deceased: Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

**Mother**

If living: Age \_\_\_\_\_ Health Status \_\_\_\_\_  
 If deceased: Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

**Sister**

If living: Age \_\_\_\_\_ Health Status \_\_\_\_\_  
 If deceased: Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

**Sister**

If living: Age \_\_\_\_\_ Health Status \_\_\_\_\_  
 If deceased: Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

**Brother**

If living: Age \_\_\_\_\_ Health Status \_\_\_\_\_  
 If deceased: Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

**Brother**

If living: Age \_\_\_\_\_ Health Status \_\_\_\_\_  
 If deceased: Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

**Son**

If living: Age \_\_\_\_\_ Health Status \_\_\_\_\_  
 If deceased: Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

**Son**

If living: Age \_\_\_\_\_ Health Status \_\_\_\_\_  
 If deceased: Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

**Daughter**

If living: Age \_\_\_\_\_ Health Status \_\_\_\_\_  
 If deceased: Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

**Daughter**

If living: Age \_\_\_\_\_ Health Status \_\_\_\_\_  
 If deceased: Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

*(If additional room needed, continue on back)*

**SOCIAL HISTORY:**

**Tobacco** use: current / infrequent / past / never

If current, # of years \_\_\_\_\_ # of packs per day \_\_\_\_\_

If past, # of years quit \_\_\_\_\_

Type of tobacco used: cigarettes / cigars /chewing tobacco / pipe / snuff

**Alcohol** use: current / infrequent / past / never

If current, # of drinks per week \_\_\_\_\_ or day \_\_\_\_\_

If past, # of years quit \_\_\_\_\_

Illicit drug use: current / past / never      Type: marijuana / cocaine / other \_\_\_\_\_

Marital Status: divorced/ legally separated / life partner / married/ married-separated / single / widowed

Birthplace \_\_\_\_\_ Hobbies \_\_\_\_\_

Occupation \_\_\_\_\_

Where do you live: house or apt / nursing home / assisted living facility / incarcerated / homeless

Who lives with you: alone / spouse / significant other / children / parents / friends / others

Circle any exposure to the following: asbestos / benzene / coal / lead / mercury/ radiation / red dye #3 / petroleum products

Xylene / other \_\_\_\_\_

Current/Previous Military: Yes / No    If yes, dates: \_\_\_\_\_ Locations: \_\_\_\_\_

Worked in an industrial plant or hospital: Yes / No    If yes, dates: \_\_\_\_\_ Locations: \_\_\_\_\_

History of blistering sunburns as a child: Yes / No

How often are you active: never / daily activities / occasional exercise / light exercise / regular exercise / extensive exercise

What is your current diet: regular diet / dietary supplements / liquid diet / diabetic diet / vegetarian / tube feeds / TPN

**ALLERGIES: List any known drug, food, or environmental allergies:**

To what

What type of reaction

Severity of reaction

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

mild / moderate / severe / life threatening  
mild / moderate / severe / life threatening  
mild / moderate / severe / life threatening

**MEDICATIONS, INCLUDING HERBAL AND OVER THE COUNTER MEDICINES:**

Name and Dose

How Often Taken

Start Date

Reason for Taking

*Ex: Hydrochlorothiazide 12.5 mg*

*Twice a day*

*2013*

*Hypertension*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(If additional room needed, continue on back)*

**PERSONAL CANCER HISTORY (if applicable):**

Type and Location of Cancer:

\_\_\_\_\_

Date of first diagnosis: \_\_\_\_\_ Stage (if known): \_\_\_\_\_

Presenting symptom(s): \_\_\_\_\_

Date/type/location of biopsy (if any): \_\_\_\_\_

Date/Year of first treatment (if any): \_\_\_\_\_

Type of treatment(s): \_\_\_\_\_

Date of relapse/progression (if applicable): \_\_\_\_\_

Subsequent treatment after relapse (if any): \_\_\_\_\_

Date and type of last treatment: \_\_\_\_\_

Date and type of last scans (if applicable): \_\_\_\_\_

Any additional information you would like to share with doctor:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The questions on this form have been answered to the best of my knowledge.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date